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BOYS WILL BE GIRLS: SEX REASSIGNMENT SURGERY AND THE ETHICS OF STATE FUNDING

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ABSTRACT

This paper was developed as a result of the author's involvement with the Nova Scotia Rainbow Action Project in Halifax, Nova Scotia, who are planning an action whereby a member of the group will submit a complaint of discrimination to the provincial Human Rights Commission, contrary to the Nova Scotia Human Rights Act, on the ground of sex. The complaint will be based on a member's denial of Nova Scotia Medical Services Insurance coverage for sex reassignment surgery, which is prohibited in Nova Scotia. This paper outlines the players and decision-making involved in determining whether or not sex reassignment surgery is funded by the state and discusses feminist theories of gender that make problematic the need for sex reassignment surgery, specifically the social construction, authenticity and transgression of gender. The author also considers both the medical diagnosis of Gender Identity Disorder and the problems with sex reassignment surgery as a treatment for this disorder. In conclusion, through a feminist ethics analysis of the different arguments for and against sex reassignment surgery, the author concludes that there is a need for the surgery to be state-funded, but that deconstructing the two-gender system could eliminate this need in the future.

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I. INTRODUCTION

The Nova Scotia Rainbow Action Project (NSRAP) is a group in Halifax, Nova Scotia, that acts as a voice for gay, lesbian, bisexual and transgendered Nova Scotians.¹ In the spring of 2004, NSRAP intends to submit a complaint to the Nova Scotia Human Rights Commission of discrimination on the grounds of sex, contrary to paragraph 5(1)(a) of the Nova Scotia *Human Rights Act*.² The complaint will be based on a denial of Nova Scotia Medical Services Insurance (MSI) coverage for sex reassignment surgery (SRC) to a member of NSRAP. The Nova Scotia *Physician's Manual*, a document that itemizes procedures insured by MSI, specifically prohibits SRC.³

The complaint by NSRAP is a deliberate tactic to use the law as a tool for social change. If the denial of SRC is found to be discrimination on the basis of sex, MSI could be ordered to cease applying the policy in the *Physician's Manual*, and transsexuals in Nova Scotia would be given access to treatment and surgery to bring their physical gender in line with their psychological gender.

In this paper I outline the players and decision-making involved in determining whether or not sex reassignment surgery is funded by the state. I then discuss feminist theories of gender that problematize the need for sex reassignment surgery, specifically the social construction of gender, performativity of gender, authenticity of gender and transgression of gender. I also consider both the medical diagnosis of Gender Identity Disorder and the problems with SRC as a treatment for this disorder. Finally, through a feminist ethics analysis of the different arguments for and against sex reassignment surgery, I conclude that while the experience of transsexuals proves there is a need for state-funded

¹ It is generally accepted that transgender is an umbrella term that includes any gender variant, such as drag kings and queens, transvestites and transsexuals. Transsexuals are people who believe they are the opposite gender that would traditionally be linked to their birth sex, and seek to become that sex by hormonal therapy or sex reassignment surgery to realign their physical body with their mental gender. I will refer to male to female transsexuals as transsexual women, and female to male transsexuals as transsexual men. A person's sex (i.e. genetic makeup, being different from gender), their self awareness and behaviour experienced and labeled as male or female. Sex and gender are again different from sexual orientation, which is the gender preference of one's sexual attraction.

² R.S.N.S. 1989, c. 214, s. 5(1).

³ Nova Scotia Medical Services Insurance, *Physician's Manual*, looseleaf (Halifax, N.S.: s.n., 197?) [the *Manual*].

SRC today, we need to work to eliminate the two-gender system which will ultimately reduce, if not eliminate, the need for SRC in the future.

II. INSURED SEX REASSIGNMENT SURGERY EXPLAINED

1. The Legislators

While health care falls under provincial jurisdiction pursuant to section 92 of the *Constitution*,⁴ health care resource allocation involves both the federal and provincial governments. The *Canada Health Act*⁵ establishes the criteria and conditions that must be met by the provinces before receiving payment for health services from the federal government.⁶

The *Act* lists a set of criteria the provinces must meet in order to receive a full cash contribution, and specifically requires that provinces fund all insured services provided by hospitals and medical practitioners.⁷ The *Act* defines “hospital services” as:

...any of the following services provided to in-patients or out-patients at a hospital, if the services are *medically necessary* for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability...⁸

The job of determining what is “medically necessary” is left to the provinces. Each province has set up a system whereby the provincial governments and medical associations negotiate the services to be included in the schedule of fees that allows physicians to be paid for their work.⁹ The allocation of decision making to the provinces means insured health services differ from province to province, and new procedures and treatments are added to the list of health services if and when a province decides to do so.

Sex reassignment surgery is one service that has been added to the list of insured services in some provinces but not in others. In Nova

⁴ *Constitution Act*, 1867 (U.K.), 30 & 31 Vict., c. 3, reprinted in R.S.C. 1985, App. II, No. 5.

⁵ R.S.C. 1985, c. 6 [the *Act*].

⁶ *Ibid.* s. 3.

⁷ *Ibid.* s. 9.

⁸ *Ibid.* s. 2 [emphasis added].

Scotia, some peripheral medical treatments involved in sex reassignment, like hormone treatment, are covered; however, surgery is explicitly deemed a non-insured procedure. SRC is an insured procedure only in Manitoba, Alberta, Newfoundland, and Saskatchewan.

Medical necessity is vaguely defined in the *Physician's Manual* published by Nova Scotia Medical Services Insurance.¹⁰ The *Manual's* preamble defines medical necessity as “those services provided by a physician to a patient with the intent to diagnose or treat physical or mental disease or dysfunction....” However, it goes on to state that services explicitly deemed non-insured remain uninsured “regardless of individual judgments regarding their medical necessity.” This means that in Nova Scotia an individual doctor has no right to determine that SRC is medically necessary for an individual patient.¹¹

2. The Doctors

The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, published by the American Psychiatric Association, is the accepted authority for the classification and diagnosis of mental disorders in North America.¹² Gender Identity Disorder (GID) is listed as a mental disorder that manifests in two ways: Gender Identity Disorder in Children, and Gender Identity Disorder in Adolescents or Adults (302.6 and 302.85).¹³

⁹ William Lahey, “Overview of the Canadian Health Care System” in *Dental Law in Canada* [forthcoming in 2004].

¹⁰ *Supra* note 3.

¹¹ Part 2.1 of the *Manual's* Preamble provides:

Medically necessary services may be defined as those services provided by a physician to a patient with the intent to diagnose or treat physical or mental disease or dysfunction, as well as those services generally accepted as promoting health through prevention of disease or dysfunction.

The provision of a service listed in the Schedule of Benefits does not ensure payment by Medical Services Insurance. Services provided in circumstances where they were not medically necessary are not insured. For the purpose of this Preamble, Medical services, which are explicitly deemed to be non-insured under the *Health Services and Insurance Act* or its Regulations, remain uninsured regardless of individual judgments regarding their medical necessity.

¹² *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, D.C.: American Psychiatric Association, 1994) [DSM-IV].

¹³ *Ibid.* at 538.

While the *DSM-IV* defines mental illness in North America, the Harry Benjamin International Gender Dysphoria Association is a professional organization dedicated to the understanding and treatment of gender identity disorders. The Harry Benjamin Association produces the *Standards of Care for Gender Identity Disorders*¹⁴ as a professional consensus about the “psychiatric, psychological, medical, and surgical management of gender identity disorders.”¹⁵ The *Standards of Care* are guidelines that provide flexible directions for the treatment of persons with GID, and specifically require a diagnosis of GID using the *DSM-IV* criteria before treatment for the disorder can begin. One of the treatments listed is sex reassignment surgery.¹⁶

If Gender Identity Disorder is a mental disorder according to the *DSM-IV*, and SRC is one treatment for GID, then it stands to reason that in some cases SRC would be medically necessary to treat this mental disorder. Given the Nova Scotia government determines medical necessity based upon the physician’s intent to “diagnose or treat physical or mental disease or dysfunction,” it should follow, barring any legislative policy decisions, that sex reassignment surgery is a service that should be insured. However, this is not the case. Because of the structure of the system for health care resource allocation, “medically necessary” is actually equivalent to “insured” and has no independent meaning outside of this legislative meaning.

3. The Policy Makers

Health care resource allocation is an important consideration to factor into funding of SRC. In his analysis of the just use of health care resources (in this case, with respect to in vitro fertilization), Leonard J. Weber

¹⁴ Harry Benjamin International Gender Dysphoria Association, *Standards of Care for Gender Identity Disorders, Sixth Version, February, 2001*, online: The Harry Benjamin International Gender Dysphoria Association, Inc. <<http://www.hbgida.org/socv6.pdf>> [*Standards of Care*].

¹⁵ *Ibid.* at 1.

¹⁶ The *Standards of Care* provide that: Sex Reassignment is Effective and Medically Indicated in Severe GID. In persons diagnosed with transsexualism or profound GID, sex reassignment surgery, along with hormone therapy and real life experience, is a treatment that has proven to be effective. Such a therapeutic regimen, when prescribed or recommended by qualified practitioners, is medically indicated and medically necessary. Sex reassignment is not “experimental,” “investigational,” “elective,” “cosmetic,” or optional in any meaningful sense. It constitutes very effective and appropriate treatment for transsexualism or profound GID. *Ibid.* at 18.

considers principles of just allocation. One of his suggestions is to establish principles to assist in the identification of what priority a particular treatment should have in the allocation of health resources.¹⁷ Weber lists five principles to help identify priority treatments. They are:

1. Treatment that, if successful, provides a significant benefit to the patient takes priority over treatment that, if successful, provides only marginal benefit.
2. A treatment that can benefit many persons generally takes priority over a treatment that can benefit only a few.
3. A treatment that is less expensive generally takes priority over a treatment that is more expensive.
4. Allocation decisions should not be made on the basis of who “merits” or “deserves” treatment.
5. Special consideration should be given to prevent a major negative impact of allocation decisions on persons with disabilities or on those who are the least powerful members of society.¹⁸

If we consider Weber’s priority principles as they impact resource allocation arguments for SRC, there is a fairly straightforward argument for insured surgery. First, SRC provides a significant benefit to the patient, offering “lasting personal comfort with the gendered self (that maximizes) overall psychological well-being and self-fulfillment.”¹⁹ Transsexual activists have noted that without treatment options many transsexuals commit suicide, are murdered, or receive inadequate medical care as a result of their transsexualism: the preservation of life is inarguably a significant benefit to a transsexual patient.²⁰ Second, transsexuals as a group are marginalized, and among the least powerful in Canadian society; special priority must be given to the treatments of Gender Identity Disorder. Surgery can be a medically necessary treatment for GID, and it is just to allocate health care resources to sex reassignment surgery.

¹⁷ Leonard J. Weber, “In Vitro Fertilization and the Just Use of Health Care Resources” in James M. Humber & Robert F. Almeder, eds., *Reproduction, Technology and Rights* (Totowa, N.J.: Humana Press, 1996) at 82.

¹⁸ *Ibid.* at 82-83.

¹⁹ *Standards of Care*, *supra* note 14 at 1.

²⁰ See e.g. “Remembering Our Dead,” online: GenderOrg Homepage <<http://www.gender.org/remember/>>.

4. The Judges

In 2003, the Federal Court of Canada dealt with the issue of essential health care and sex reassignment surgery in the context of a male to female transsexual serving a life sentence for murder.²¹ A transsexual woman initiated a complaint with the Canadian Human Rights Commission alleging discrimination on the basis of sex and disability. Her complaint was made against the Correctional Service of Canada's (CSC) policies regarding transsexual inmates, namely CSC's policy on placement of pre-operative transsexual inmates and their prohibition of sex reassignment surgery for incarcerated individuals. With regard to the prohibition on surgery, CSC's policy at the time was that sex reassignment surgery was not to be considered during the inmate's incarceration.²²

The *Corrections and Conditional Release Act*²³ mandates that every inmate must be provided with essential health care. The definition of essential health care in section 87(1) of CSC's policies is:

Inmates shall have access to screening referral and treatment services. Essential services shall include [...] mental health care provided in response to disturbances of thought, mood, perception, orientation or memory that significantly impairs judgement, behaviour, the capacity to recognize reality or the ability to meet the ordinary demands of life. This includes the provision of both acute and long-term mental health care services...²⁴

The Human Rights Tribunal found that for some people sex reassignment surgery constituted a legitimate, medically recognized treatment for transsexualism. Further, the Tribunal found that in some cases SRC could be essential. On judicial review, Layden-Stevenson J. agreed with the Tribunal and found that SRC could be an essential health service. She wrote:

Essential health care, pursuant to CCRA (subsection 86(1)), is provided to inmates. The provision is mandatory. If sex reassignment surgery is determined to be essential, subsection 86(1) applies.

²¹ *Canada (Attorney General) v. Canada (Canadian Human Rights Commission)*, 2003 FCT 89, [2003] F.C.J. No. 117 (QL: FCJ) [AG v. CHRC].

²² *Ibid.* at para. 3.

²³ S.C. 1992, c. 20.

²⁴ AG v. CHRC, *supra* note 21 at para. 8.

[...] I do not take issue with the conclusion that the role of the court is limited when reviewing policy-based determinations by officials who are accountable for public funds. However, the right of government to allocate resources as it sees fit is not unlimited. “It must be exercised according to law. The government’s right to allocate resources cannot override a statute such as the *Canadian Human Rights Act*”...²⁵

Not only did Layden-Stevenson J. find that SRC was an essential health service, but she also found that Correctional Services Canada was required to pay for the surgery. She relied on the Harry Benjamin *Standards of Care* assertion that sex reassignment surgery can be medically necessary as well as expert evidence that untreated transsexualism can lead to individuals suffering from disabling torment.²⁶ In light of this decision, the answer to the question of whether or not MSI should fund sex assignment surgery seems to be a straightforward “yes.”

III. THE GENDER PROBLEM

In their groundbreaking 1978 book *Gender: An Ethnomedical Approach*, anthropologists Suzanne Kessler and Wendy McKenna introduced the concept of looking at gender as a social construct.²⁷ Kessler and McKenna argue that gender identity refers to an individual’s own feelings about whether he or she is a man or woman (girl or boy), and that gender identity is a *self-attribution* of gender. They point out that:

...by what criteria a person might classify someone as being either male or female, the answers appear to be so self-evident as to make the question trivial. But consider a list of items that differentiate females from males. There are none that *always and without exception* are true of only one gender. No behavioural characteristic (e.g., crying or physical aggression) is always present or never present for one gender. Neither can physical characteristics—either visible (e.g., beards), unexposed (e.g., genitals), or normally unexamined (e.g., gonads)—always differentiate the genders.²⁸

²⁵ *Ibid.* paras. 51-52.

²⁶ *Ibid.* para. 41.

²⁷ Suzanne J. Kessler & Wendy McKenna, *Gender: An Ethnomedical Approach* (New York: John Wiley and Sons, 1978) [*Gender*].

²⁸ *Ibid.* at 8.

Kessler and McKenna speak of “gender attribution” as the moment when we decide someone is male or female.²⁹ When we are born we are attributed gender when the doctor looks at our genitals; save for cases of ambiguous genitalia,³⁰ this is a fairly simple process.

However, Kessler and McKenna question the rigid and dichotomous nature of gender attribution, and highlight the fact that ambiguous cases bring to light the value society ascribes to the bipartite gender attribution process.³¹ They go on to consider the gender attribution process throughout one’s life, and argue that people make gender attributions—decisions about whether someone is male or female—every time they meet someone new. When we subconsciously look for signs of breasts to identify women (although not all women have noticeable breasts and not all men lack breasts), signs of a beard to identify men (although not all men have a noticeable beard and not all women lack beards), and a whole range of other gender signifiers, we are simply “determining,” for the moment, whether a person is *either* male or female. But more than just a sweeping inspection to determine gender, Kessler and McKenna argue that “...*gender attribution forms the foundation for understanding other components of gender*, such as gender role (behaving like a female or male) and gender identity (feeling like a female or male).”³²

If gender is socially constructed, it should follow that one could learn and adopt social signifiers of the opposite sex (e.g. “masculine” dress or “feminine” hand gestures). Combined with the ability to medically alter one’s body to possess biological signifiers of the opposite sex (e.g. “male” Adam’s apple or “female” breasts), it becomes possible to achieve a state of “being” the opposite gender. Sociologist Myra J. Hird found that in the 1990’s a “distinct set of transsexual narratives began to argue that if gender can be learned then ‘womanhood’ (and ‘manhood’)

²⁹ *Ibid.* at 2.

³⁰ In her book *Hermaphrodites and the Medical Invention of Sex* (Cambridge: Harvard University Press, 1998) at 4, historian Alice Dreger discusses the history of hermaphroditism. She writes that “some people—more than is generally assumed—are born with an anatomical conformation different from ‘standard’ male or female bodies. Their unusual anatomies can result in confusion and disagreement about whether they should be considered female or male or something else. These people have for centuries been labeled as ‘hermaphrodites’...”

³¹ *Gender*, *supra* note 27 at 3.

³² *Gender*, *supra* note 27 at 2 [emphasis in original].

is available to anyone with the capacity to learn.”³³ Thus, transsexualism provides us with evidence that gender is an expression of sex using signifiers which have been both created and approved by society.

Adding to Kessler and McKenna’s concept that gender attribution is the building block for understanding other components of gender is Judith Butler’s notion of the *performativity* of gender.³⁴ Performativity rests on the argument that gender is constructed, and that we will never know our sex outside of our gender because we perform our gender according to the acts, gestures, and desires that are the organizing principles of identity. At birth, we’re assigned a gender according to that sex. As we grow up we adopt social signifiers of gender. Women wear makeup, men keep their hair and nails short, women sit with their legs crossed and men undo their jackets when they sit down. There are a myriad of social signifiers, from dress to mannerisms, which we perform to display our sex, through gender, when our biological sex is covered. Butler takes this idea one step further and asks what, if anything, is left of “sex” once it has assumed its social character of gender? If gender is socially constructed by what we assume of sex, then sex doesn’t acquire social meaning but instead is replaced by gender.³⁵ Butler argues that since gender *is* the social signifier of sex, that sex *is*, in effect, gender.

This circular sex/gender theory is supported by Kessler and McKenna’s earlier work. They write, “[T]he reality of gender is proved by the genital which is attributed and at the same time the attributed genital only has meaning through the socially shared construction of gender attribution.”³⁶ Hird refers to the signifiers we rely on to make gender attributions as “cultural genitals.”³⁷ Butler goes so far as to suggest that all we have are “cultural genitals”: that if there is no access to “sex” but through these signifiers then “sex” itself is something of a fiction or fantasy.³⁸

³³ Myra J. Hird, “For a Sociology of Transsexualism” (August 2002) 36:3 *Sociology* 577 at 584 [*Sociology*].

³⁴ Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990) at 136.

³⁵ Judith Butler, *Bodies That Matter: On the Discursive Limits of “Sex”* (New York: Routledge, 1993) at 4 [*Bodies That Matter*].

³⁶ *Gender*, *supra* note 27 at 8.

³⁷ *Sociology*, *supra* note 33 at 588.

³⁸ *Sociology*, *supra* note 33 at 5.

All these overlapping theories hinge on sex and gender as mutable and socially constructed, but, more importantly, they call into question the value of SRC. If “becoming” the opposite sex is achievable through performance, then genital reconstruction through sex reassignment surgery should be unnecessary—arguably one could rely on constructing “cultural genitals” to effect a successful sex reassignment.

But what if performativity is linked to biology and the body? Ethicist Janice Raymond’s 1979 book *The Transsexual Empire* was one of the first books to challenge the medical/psychiatric concept of transsexualism and SRC as the cure, and instead questions the concept of gender itself.³⁹ But Raymond still insists on gender’s link to biology. She repeatedly references the *feminization* of a man or the *masculinization* of a woman when she discusses sex reassignment surgery and “becoming” the other sex. She agrees that masculinity and femininity are social constructs and stereotypes of behaviour that are imagined in a particular body, but argues these stereotypes, “...in the case of the transsexual, have nothing to do with a male or female body. Thus the male-to-constructed-female goes from one stereotype to the other.”⁴⁰ She points out that SRC is a surgical construction to bring a person’s body in line with the stereotyped behaviour. Nonetheless, she distinguishes masculinity and femininity from “male” and “female.” The former are socially and surgically constructed; the latter are governed by biology and the vast history surrounding that biology.⁴¹

Raymond does not see gender as immutable, but at the same time she is unwilling to accept that a transsexual can change his or her sex. While she does not believe that chromosomal sex *defines* gender, she uses Kessler and McKenna as a jumping off point to argue that chromosomal sex *shapes* gender. She writes that in the case of women, female biology has shaped female history, including:

...the history of menstruation, the history of pregnancy or the capacity to become pregnant, the history of childbirth and abortion, the history of certain bodily cycles and life changes, and the history of female subordination in a male-dominant society.⁴²

³⁹ Janice Raymond, *The Transsexual Empire: The Making of the She-Male* (New York: Teacher’s College Press, 1994) [*Transsexual Empire*].

⁴⁰ *Ibid.* at 3.

⁴¹ *Ibid.* at 4.

⁴² *Ibid.* at 7.

It is this link to biology that centres Raymond's arguments in the "authenticity" of gender. One writer on transsexualism notes:

There is hardly a more dramatic instance of contemporary professional authority than so-called 'sex change surgery.' Physicians perform cosmetic surgery yet certify that their patients have undergone a change in sex.⁴³

However, most in the medical community do not view SRC as changing a person's sex or gender,⁴⁴ because society, which includes the medical community, assumes that sex exists as a measurable and immutable trait. Raymond deconstructs that assumption and roots it in history and experience, while at the same time coming to a similar conclusion about sex and the authenticity of sex.

Raymond and Butler have incompatible views on the topic of "sex". Raymond roots part of how we imagine sex in biological and historical realities, while Butler reasons that the performativity of gender replaces sex and renders those realities obsolete categorizations. Nonetheless, both leave us wondering about the priority of sex reassignment surgery. If we accept that gender is performance, then there is no need to physically change one's genitalia in order to "become" the other sex. Conversely, if Raymond is correct in her linkage of sex to biology, then no amount of surgery will transform transsexuals into the other sex. In fact, Raymond not only questions the value of SRC but argues against it; she believes that SRC and transsexualism undercut the movement "to eradicate sex-role stereotyping and oppression in this culture. Instead it fosters institutional bases of sexism under the guise of therapy."⁴⁵

Looking back to Weber's principles of health resource allocation, one must question the "significant benefit" achieved by SRC in light of these theories. Is there a "significant benefit" if sex reassignment can be achieved without surgery, or if sex reassignment can never happen, even with surgery? Surely a successful surgery could maximize psychological well-being and self-fulfillment, but how can a benefit be justified

⁴³ Dwight D. Billings & Thomas Urban, "The Socio-Medical Construction of Transsexualism: An Interpretation and Critique" in *Blending Genders: Social Aspects of Cross-dressing and Sex-changing*, Richard Ekins & Dave King, eds., (New York: Routledge, 1996) at 99 [*Construction of Transsexualism*].

⁴⁴ *Sociology*, *supra* note 33 at 582.

⁴⁵ *Transsexual Empire*, *supra* note 39 at 5.

when the treatment is comparable to a placebo? If these theories are correct, other treatments for Gender Identity Disorder need to be prioritized over SRC—if SRC should be given a priority at all.

Another concept that complicates support of SRC is the proposition of gender transgression: “playing” with notions of gender with the intended effect of rendering the two-gender system obsolete. The assumed characteristic of gender in our discussion thus far is that there are only two sexes (male/female) and two genders (masculine/feminine). Sex and gender are generally accepted as contemporaneous states. Both male and female sexes are ordered by a set of stereotypes/signifiers that are imagined as attributable to a particular body. Transsexuals render these signifiers visible,⁴⁶ offering us a chance to both question and play with them. Butler considers drag, dressing in the clothing appropriate for the opposite sex for the purpose of performing, to be one example of the transgression of gender. Using Foucault’s language of power and resistance, she writes that sometimes:

...the transferability of a gender ideal or gender norm calls into question the abjecting power that it sustains. For an occupation or reterritorialization of a term that has been used to abject a population can become the site of resistance, the possibility of an enabling social and political resignification.⁴⁷

Similarly, transsexual Kate Borenstein argues that transsexuals aren’t men *or* women, not because they are “inauthentic,” but because transsexuals, by their very existence, radically deconstruct sex and gender.⁴⁸ She believes that gender is not consensual:

We’re born: a doctor assigns us a gender. It’s documented by the state, enforced by the legal profession, sanctified by the church, and it’s bought and sold by the media. We have no say in our gender—we’re not allowed to question it, play with it, work it out with our friends, lovers or family.⁴⁹

⁴⁶ *Sociology*, *supra* note 33 at 586.

⁴⁷ *Bodies That Matter*, *supra* note 35 at 230.

⁴⁸ Kate Borenstein, *Gender Outlaw: On Men, Women and the Rest of Us* (New York: Routledge, 1994) [*Gender Outlaw*].

⁴⁹ *Ibid.* at 123.

Borenstein calls for people to question gender, to subvert it, deconstruct, it and reconstruct it. Through the transgression of gender, the lines of gender categories will blur and people will be free to construct their own gender (or not), in the way that they see fit. Being a drag king or queen, a crossdresser, transgendered, butch or femme, a transvestite, two-spirited, or gender variant in any other way pushes the boundaries of society's definition of male/masculine and female/feminine as much as transsexuality. Transgression can be an important step in challenging the two-gender system.

However, it is difficult to argue that all forms of transsexualism are subversive. Raymond identifies a transgression as being hyper-conformity to sex-roles.⁵⁰ It is hard to avoid the fact that hormones and surgery reify hegemonic gender norms.⁵¹ Especially in the context of the *Standard of Care's* requirement of "passing," transsexuals are expected to be ultra-masculine or ultra-feminine, reproducing the extreme end of either gender. Anticipating the flaws in her argument for transgression, Butler calls into question "...whether parodying the dominant norms is enough to displace them; indeed, whether the denaturalization of gender cannot be the very vehicle for a reconsolidation of hegemonic norms."⁵²

Sex reassignment surgery both confirms and legitimizes sex and gender norms. In fact, part of the reason that SRC has been supported by mainstream medicine may be because it is an example of the binary gender system prevailing even in the face of perversion, mental dysfunction, and sickness: despite the transsexual's illness, he or she simply wants to become the *other* gender. Transsexualism is easy to understand, support and cure so long as the two-gender system is upheld. It is when true gender variance is proposed, like introducing a third gender category that transgression becomes more like the vehicle of liberation it has been proposed to be.

⁵⁰ *Transsexual Empire*, *supra* note 39 at 216.

⁵¹ *Sociology*, *supra* note 33 at 590.

⁵² *Bodies That Matter*, *supra* note 35 at 125.

IV. THE MEDICAL PROBLEM

Michel Foucault, in *The History of Sexuality*, describes the “medicalization of the sexually peculiar” as a nineteenth century phenomenon—one which was both an effect and an instrument of the power of health and pathology.⁵³ This medicalization was focused on biological anatomy as the centre of truth; the medical scientist was a discoverer of truth, and through his scientific explorations he alone could solve the problems that the peculiar posed. Hird argues that the history of transsexualism is a history of pathology, and points out that the word “transsexual” itself is a psychological and medical classification⁵⁴—a specific situation where the “truth” of anatomy did not match the “truth” in a patient’s mind.

While the history of transsexualism is a story that closely parallels, and oftentimes overlaps with, the histories of homosexuality and hermaphroditism,⁵⁵ transsexualism does have its own unique medical and social history. There is evidence of hormone therapy given to male transsexuals to stimulate breast development as early as the 1920’s, but any gender variant people who sought medical treatment were labelled as “transvestites” and treated as isolated cases. The transsexual “emerged” in the early 1950’s with the widely publicized operation on Christine Jorgensen in Denmark and was soon followed by the coining of the term “transsexual” by Dr. Harry Benjamin.⁵⁶ Prior to this time, transsexualism had been dismissed as a perversion; with the operation on Christine Jorgensen, there emerged a medical “cure”. Sex change advocates worked to legitimize surgical treatment by constructing theories about transsexualism that stressed the non-psychopathic nature of the illness and by rationalizing diagnostic and treatment strategies.⁵⁷ Transsexualism was further medicalized and legitimized when it received the new

⁵³ (New York: Vintage Books, 1990) at 44.

⁵⁴ *Sociology*, *supra* note 33 at 579.

⁵⁵ For a history of hermaphroditism, see, for example, Alice Dreger’s book *Hermaphroditism and the Medical Invention of Sex*, *supra* note 30. For a history of homosexuality see, for example, Jeffery Weeks, *Against Nature: Essays on History, Sexuality, Identity* (London: Rivers Oram, 1991).

⁵⁶ For a history of transsexualism see, for example, “Gender Blending,” *infra* note 58 (social history), and Leslie M. Lothstein, “Sex Reassignment Surgery: Historical, Bioethical, and Theoretical Issues” (1982) 139:4 *Am J Psychiatry* 417 [*Sex Reassignment Surgery*].

⁵⁷ *Construction of Transsexualism*, *supra* note 39 at 104.

name of “gender dysphoria” in the 1970’s, a term that moved away from the person and toward the condition; thus the term named a disease that was to be the property of the medical profession.⁵⁸

In 1980, Gender Identity Disorder appeared in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, and it is still included in the *Manual’s* most recent fourth edition.⁵⁹ The diagnostic criteria for adults and adolescents are:

- A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex). In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
- B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex. In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.
- C. The disturbance is not concurrent with a physical intersex condition.
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.⁶⁰

Forms of illness are more than just biological disease; they are also metaphors, and possess both moral and social meaning.⁶¹ If we consider the social meaning of gender implicit in the *DSM-IV’s* criteria for transsexuality, it is apparent that there are only two genders, and that both genders are tangible, achievable things: gender is something you are,

⁵⁸ Dave King, “Gender Blending: Medical Perspectives and Technology” in *Blending Genders: Social Aspects of Cross-dressing and Sex-changing*, Richard Ekins & Dave King, eds., (New York: Routledge, 1996) at 96.

⁵⁹ Interestingly, “homosexuality” as a disorder was removed from the second edition in 1973.

⁶⁰ *DSM-IV*, *supra* note 12 at 538.

⁶¹ *Construction of Transsexualism*, *supra* note 43 at 112.

you can be, and that you can identify. For example, “frequent passing as the other sex” relies on the transsexual’s interpretation (or society’s interpretation) of the characteristics of a particular sex; diagnosing the disorder depends on the subject’s success at “passing”—success that relies on the medical practitioner’s interpretation of what it means to be a man or woman, and whether or not the transsexual’s performance was good enough. According to the *Manual*, male and female characteristics are quantifiable, and although the specifics of what constitutes “typical feelings and reactions of the other sex” aren’t listed, it is clear that they are expected to be both known and understood by patient and doctor. Kessler and McKenna write about one doctor who used his own sexual attraction to a patient as a gauge for determining the “validity” of his patient’s claim of transsexuality.⁶² In more recent writing, Dwight Billings and Thomas Urban describe a doctor’s evaluation methods to include antagonizing his genetic male patients to the point where they lash out and he could properly assess their behaviour: gays get aggressive, “girls” cry.⁶³

Even if we disregard these extreme examples and dismiss them as unfortunate worst-case scenarios, it is still clear that the diagnostic criteria still rely on sex stereotyping and views gender strictly through a medical lens. In the introduction to the section on GID, the *DSM-IV* states, “Gender Identity Disorder can be distinguished from simple non-conformity to stereo-typical sex role behaviour by the extent and pervasiveness of the cross-gender wishes, interests and activities.”⁶⁴ According to the *DSM-IV*, deviation from society’s biologically determined sex roles is acceptable, so long as you don’t go too far. The criteria also focus on symptoms that the illness can manifest, namely, significant distress or impairment with regards to functioning in society.

Transgendered people do suffer distress and impairment in society—from “intolerance, discrimination, violence, undeserved shame, and denial of personal freedoms that ordinary men and women take for granted.”⁶⁵ The *DSM-IV* criteria for GID are so ambiguous and rely on such negative and sexist stereotypes that the simple first step of diag-

⁶² *Gender*, *supra* note 27 at 58.

⁶³ *Construction of Transsexualism*, *supra* note 43 at 110.

⁶⁴ *DSM-IV*, *supra* note 12 at 537.

⁶⁵ Katherine K. Wilson, “Gender as Illness: Issues of Psychiatric Classification,” online: <<http://www.transgender.org/tg/gidr/kwictl97.html>> at subheading “Blaming the Victim.”

nosis calls into question the ethics of any treatment available for GID and begs the question: is the diagnosis even right? Leslie Lothstein, in the *American Journal of Psychiatry*, found that clinicians who advocate SRC as a legitimate treatment see it as a cure, and believe that psychotherapy is useless for patients with GID. Doctors who view SRC as an illegitimate treatment point to the "...complex psychological, medical, legal, bioethical and political issues that are neglected or bypassed by sex reassignment surgery procedures. They argue that sex reassignment surgery leads to mistreatment and mismanagement of the gender dysphoric patient."⁶⁶ Lothstein cites several studies where patients were satisfied with the procedure and there is evidence of positive life changes;⁶⁷ however, Billings and Urban point out that patients can "ill afford to be critical of such a profound alteration as genital amputation."⁶⁸

Once a person has been diagnosed with GID, the patient is a candidate for treatment. The Harry Benjamin International Gender Dysphoria Association produces clinical guidelines intended to provide "flexible directions for the treatment of persons with gender identity disorders."⁶⁹ The *Standards of Care* explain that after diagnosis of Gender Identity Disorder, the therapeutic approach usually includes three phases:⁷⁰ real life experience in the desired role, hormones of the desired gender, and surgery to change genitalia and other sex characteristics.⁷¹ The minimum eligibility requirements for genital surgeries apply to genetic men and genetic women seeking surgery, and are:

1. Legal age of majority in the patient's nation;
2. Usually 12 months of continuous hormonal therapy for those without a medical contraindication;

⁶⁶ *Sex Reassignment Surgery*, *supra* note 56 at 417.

⁶⁷ *Ibid.*

⁶⁸ *Construction of Transsexualism*, *supra* note 43 at 108.

⁶⁹ *Standards of Care*, *supra* note 14 at 1.

⁷⁰ The *Standards of Care* note that clinicians have found that not all persons with GID need or want all three phases of therapy. Typically the treatment occurs in the order of hormones, real-life experience, followed by surgery, but that there are a variety of treatment options of which completion of the three phases is only one option. For example, Layden-Stevenson J. noted that the real-life experience phase could not be satisfactorily fulfilled in prison.

⁷¹ *Standards of Care*, *supra* note 14 at 3.

3. 12 months of successful continuous full time real-life experience. Periods of returning to the original gender may indicate ambivalence about proceeding and generally should not be used to fulfill this criterion;
4. If required by the mental health professional, regular responsible participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the patient and the mental health professional. Psychotherapy per se is not an absolute eligibility criterion for surgery;
5. Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches;
6. Awareness of different competent surgeons.

Readiness Criteria

1. Demonstrable progress in consolidating one's gender identity;
2. Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health; this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance.⁷²

The diagnostic criteria rely on assumptions that transsexuals are a homogeneous group, that the transsexual is sick and needs standardized care, and that the transsexual suffers from an illness that subverts social and cultural variables.⁷³ In particular, the criterion of real-life experience, like passing, is based on how sex roles are imagined in a society and the behaviours attributed to either sex. The methods used to allow transsexuals to change from one gender to the other are rigid, prescribed, and regularized,⁷⁴ leaving little room for the challenges to or transgression of gender that Butler and Borenstein propose.

⁷² *Standards of Care*, *supra* note 14 at 20.

⁷³ Anne Bolin, *In Search of Eve: Transsexual Rites of Passage* (New York: Bergin & Garvey, 1998) at 53 [*In Search of Eve*].

⁷⁴ *Ibid.* at 6.

The diagnostic criteria combined with the *Standards of Care* lead to what Billings and Urban describes as “the con.”⁷⁵ Transsexuals often know what it takes to pass, and will put that knowledge to good use. In her study of male to female transsexual communities, Anne Bolin describes a veritable underground network of information on how to “pass”⁷⁶—both the tests put to a person by their doctor (passing as a “real” transsexual) and the tests put to a person by society (passing as a “real” woman or man). She points out that the role of the psychiatrist is that of gatekeeper, and that the gatekeeper has a certain expectation of what it is to be male or female. In her study, she found that as a group, male to female transsexuals are highly motivated to score as feminine.⁷⁷ Medical and psychiatric communities rely on and reinforce sex-role stereotypes and cultural expectations. Transsexuals know this expectation exists and instead of re-educating they choose to conform to those expectations: a man’s view of a “real” woman. Borenstein describes how she had her genital surgery because of cultural pressure, and that she didn’t fit in a male body so she must have belonged in a female body.⁷⁸ People who are vulnerable in our society cannot risk alienating the people who hold the power; thus transsexuals are forced into medicine’s culture of genital imperatives.

V. CONCLUSION

Medically, challenges to the validity of diagnosis and treatment of transsexuals problematize the “cure” of sex reassignment surgery to the point that one wonders not only if SRC is ethical but is it safe? Socio-cultural critiques of the societal norms upon which Gender Identity Disorder and its treatment are based illustrate the harm being done both to transsexuals and other vulnerable people in society (particularly women) who continue to be marginalized by patriarchal power structures that uphold the two-gender system. A feminist approach to ethics calls on women to resist and overcome their oppression under patriarchy;⁷⁹ this is what

⁷⁵ *Construction of Transsexualism*, *supra* note 43 at 108-109.

⁷⁶ *In Search of Eve*, *supra* note 73 at 50-52.

⁷⁷ *In Search of Eve*, *supra* note 73 at 108.

⁷⁸ *Gender Outlaw*, *supra* note 48 at 119.

⁷⁹ Rosemary Tong, *Feminine and Feminist Ethics* (Belmont: Wadsworth Publishing Co., 1993) at 164 [*Feminine and Feminist Ethics*].

Raymond is trying to achieve when she supports moralizing transsexualism out of existence.

The problem with these criticisms is twofold. First, arguing that SRC is unethical undermines both the agony of and the choices made by transsexuals. Transsexuals experience very real alienation, discomfort, and dislike of the sex to which their bodies assign them. Similarly, transsexuals experience very real discrimination, intolerance, violence and denial of personal choice and freedoms as a result of their gender and gender identity. Deconstructing GID and SRC from this feminist viewpoint further marginalizes transsexuals and removes their voice and their right to choose. One marginalized group can not reserve the right to speak for another; this simply recreates oppressive power structures in another form. Perhaps the desire or need for SRC *is* socially constructed, but simply deconstructing the desire or need to conclude that SRC is “wrong” delegitimizes the choices made by individuals. Bolin points out that transsexuals are not participating in a feminist speech revolution—they simply want to “pass.”⁸⁰ Their needs or desires must be respected. It is wrong to deny access to SRC based on the moral decision-making of those people who already fit into the two-gender system—even if those people actually want out of it, and see SRC as one more obstacle to getting out.

The second problem is that feminist ethics should not only criticize practices that oppress but also imagine “morally desirable” alternatives to them and offer “morally justifiable” ways to resist them.⁸¹ Raymond and Butler’s arguments do neither. Billings and Urban look to therapy as one answer because transsexuals lack the language “to express the disparate and diverse desires which lead them to body mutilation.”⁸² Therapy would allow people to step away from the “for” or “against” arguments around SRC and allow patients to criticize society and struggle against the crippling effects of social institutions.⁸³

While Billings and Urban present one alternative, their focus is still on the transsexual as an object of social change. In supporting the characteristically male aspects of ethics like independence, autonomy and

⁸⁰ *In Search of Eve*, *supra* note 73 at 135.

⁸¹ *Feminine and Feminist Ethics*, *supra* note 79 at 164.

⁸² *Construction of Transsexualism*, *supra* note 43 at 112.

⁸³ *Construction of Transsexualism*, *supra* note 43 at 112-115.

choice, we are subverting the feminine and feminist aspects of community, care, and trust. Sex reassignment surgery may not actually heal the mind or body, but it serves a moral function:⁸⁴ SRC allows transsexuals to choose the treatment they require as needed and validates their experiences as gender variant. This aspect of SRC is compatible with and can coexist with a feminist deconstruction of Gender Identity Disorder and the need for SRC. A feminist approach can understand the authentic experience of transsexuals today and, at the same time, look towards the future and work to eliminate the two-gender system to allow for different choices for future people. Fitting with Weber's framework, this certainly produces the most significant benefit for the most number of people.

⁸⁴ *Construction of Transsexualism*, *supra* note 43 at 99.